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Pelvic Pain in Pregnancy

By Kate Jordan, NCTMB

The most common reason women seek the services of massage therapists during pregnancy is for back pain. In order to treat such discomfort effectively, it is helpful to differentiate between pain originating in the lumbar spine and pain arising from dysfunction in the posterior pelvis.

Pregnancy places unique stresses on weightbearing joints in the torso.
As a woman’s pregnancy progresses, her uterus enlarges, moving her center of gravity forward of her feet. This causes her to rotate her rib cage posteriorly, shifting her weight to the lumbosacral joint and the sacroiliac joints in the pelvis.

Numerous studies of back pain in pregnancy have found that as many as 50% of pregnant women experience some back pain, and 10% experience severe pain. About 30% of these women had no history of previous back pain.

When women make pain drawings of their back pain, only 25% show pain in the lumbar area. More than 50% draw their pain below the crest of the ilium and lateral to the sacrum. They describe this pain as deep in their gluteal area, traveling down the back of the thigh. Even though this appears to be "sciatic" pain, only about one of every 10,000 pregnant women have actual disc disease in pregnancy, and usually those who do had disc problems before they got pregnant.

The number of women complaining of back pain in pregnancy has increased in the past 20 years perhaps because more women are working, often in ergonomically stressful jobs. In one study in Sweden, 70% of all working pregnant women took sick leave, mostly for back pain.

It’s important to differentiate between lower back pain and pelvic pain. They should be approached in different ways, and the treatment for back pain may make pelvic pain worse. A woman whose back pain

comes from her pelvis will locate it in her gluteal region on one or both sides; she will have a free range of motion in her back and hips; and her pain will not be constant, but related to the movements she makes.

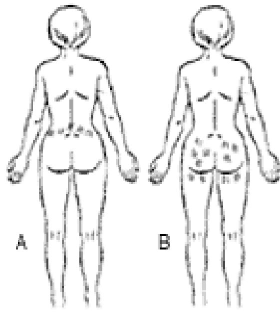
There is a simple test that will confirm that a womens pain originates in the pelvis, rather than being referred from another area. This is called the posterior pelvic pain provocation test. With your client well-supported in a side-lying position, with her painful side facing up, position her upper leg in 90 degrees of hip flexion, with flexed knee on a pillow support. With one hand stabilizing her sacrum, compress the knee and femur into the acetabulum. If this pressure reproduces her pain, either in the *symphysis pubis* or the sacroiliac area, her pain is likely to be coming from one of the ligaments around those joints.

Pelvic changes in pregnancy were noticed as far back as the days of Hippocrates. The pregnancy hormones relaxin, estrogen and progesterone cause a measurable widening of the pubic symphysis anteriorly, and a shifting of the SI joint posteriorly. Widening of the pubic symphysis begins as early as the eighth week of pregnancy. Any pain felt in the pubic symphysis is a direct result of dysfunction in the sacral area.

Pelvic pain may be noticed around the 18th week of pregnancy. Women experience higher pain intensity with pelvic pain than back pain, and the higher a woman's relaxation levels, the more pain she will experience. This pain is caused by stretching of the pelvic ligaments, causing the pelvic muscles to attempt to establish stability by increasing muscle tension, leading to chronic pain in the area. Because the discomfort is primarily caused by hormonal changes, it cannot be prevented during pregnancy.

On the other hand, secondary muscle pain can be prevented. If your client receives supportive bodywork during her pregnancy, she is likely to have no further pain after her baby is born. Some studies have shown that more than 35% of women who had no treatment during pregnancy suffered persistent pelvic pain afterward.

In particular, if a woman has pelvic pain, she should not be encouraged to do back exercises, or any kind of vigorous exercise. Exercise will only increase her pain, especially the following day. She should avoid stairs, standing on one leg, extensive walking, extreme ranges of motion of her back and pelvis, standing, heavy lifting and prolonged sitting. She should also avoid bed rest, since this will weaken supportive

muscles. 

Location of low back pain (A) vs. posterior pelvic pain (B). One of the most helpful support measures for pelvic pain is the use of a pelvic belt. These should be worn throughout the pregnancy whenever your client is upright. Bodywork techniques should focus on the pelvic musculature, particularly the *gluteus maximus,gluteus medius,* lateral hip rotators, the hamstrings, hip adductors, the *rectus femoris,* and the *quadratus lumbuorum.* Techniques that will be particularly effective for pelvic pain include neuromuscular therapy, muscle energy techniques, and positional release techniques. Clients should also be taught side-lying positioning that supports a neutral pelvis (no rotation) for sleeping and resting.

After giving birth, posterior pelvic pain disappears in most women within three months. When a woman begins to exercise again, she should start with strengthening exercise for her pelvic muscles, before she begins any back exercise.

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